Qualitest
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qualitestrx.com

Qualitest
an endo international company

RECALL RESPONSE FORM

VOLUNTARY RECALL – RETAIL LEVEL

PRODUCT DESCRIPTION	NDC NUMBER	LOT #	EXP DATE	Units Returning
Ranitidine Syrup, 15mg/1mL, 16 fl. oz. bottle	0603-9418-58	L088L13A	12/15	
Ranitidine Syrup, 15mg/1mL, 16 fl. oz. bottle	0603-9418-58	L023F14A	5/16	
Ranitidine Syrup, 15mg/1mL, 16 fl. oz. bottle	0603-9418-58	L024F14A	5/16	

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the recall instructions and have taken the appropriate action.

The affected product was distributed by Qualitest between August 4, 2014 and June 26, 2015.

Store Name _____ DEA #_____

**DEA # is required, if not provided the processing of your form will be delayed.*

Address_____

City_____ State_____ Zip_____

Contact Name (please print)_____ Telephone #_____

Contact Signature _____ Date_____

I have notified my customers that were sold/shipped affected recalled product

Circle one: YES or NO-I did not sell/ship affected product.

I have checked my stock and:

_____Do not have any stock of the recalled products listed above. OR

Have quarantined and listed in the box above the quantity of units the above product lots. I will be returning to CLS MedTurn, an Inmar company, as soon as possible. Upon receipt of this Response Form, CLS MedTurn, an Inmar company, will issue return authorization labels _____(please indicate the # of box labels needed.)

If you did not purchase the product directly from the Manufacturer please complete the below section.

Purchased From: Name _____ DEA #_____

Address_____

City_____ State_____ Zip_____

If you have any questions regarding this form or product return please contact
CLS MedTurn, an Inmar company at 1-800-967-5952
Please fax this form to: 1-817-868-5362 or E-mail at: rxrecalls@inmar.com